

CHUBB®

Western Claim Service Center
2155 W. Pinnacle Peak Road
Phoenix, AZ 85027

Mailing Address
P.O. Box 42065
Phoenix, AZ 85080
O (800) 262-4459
F (800) 664-1765

RECEIVED

FEB 21 2020

Pacific Workers'

February 18, 2020

Christian Charles Colantoni
Colantoni, Collins, Marren, Phillips and Tulk
201 Spear Street Suite 1100
San Francisco, CA 94105

Farber & Co
333 Hegenberger Road, Suite 504
Oakland, CA 94621

Re: Employee: Jonathan Shockley
Employer: Biotelemetry Inc
Date of Injury: 2/15/2019
Claim Number: 040519008736
Policy Number: 000071738154 / 000090
Writing Company: Chubb Indemnity Insurance Company

In accordance with the Rules of Practice and Procedures of the Workers' Compensation Appeals Board, we submit the following:

- _____ Duly executed Compromise & Release Agreement for your approval.
- _____ Stipulations with Request for Award.
- _____ Declaration of Readiness to Proceed.
- _____ Answer.
- _____ Other:
- ☒ x Medicals as follows: All Medicals received from 12/20/19 -02/18/20

Pain & Rehabilitative dated 11/22/19, 01/10/20, 01/15/20
Andreas Schwerte, O.M.D., LAc dated 11/05/19

Very truly yours,

Mario Castro
Claims Examiner

**PROOF OF SERVICE
1013A (3) CCP**

STATE OF CALIFORNIA, COUNTY OF CONTRA COSTA

I am employed in the County of Contra Costa, State of California. I am over the age of 18 and not a party to the within action. My business address is PO Box 42065, Phoenix, AZ 85080.

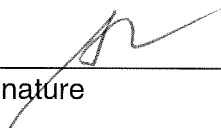
On I served the foregoing document described as a medical reports, on the interested parties in this action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at San Ramon, California addressed as follows:

Christian Charles Colantoni
Colantoni, Collins, Marren, Phillips and Tulk
201 Spear Street Suite 1100
San Francisco, CA 94105

Farber & Co
333 Hegenberger Road, Suite 504
Oakland, CA 94621

Executed on February 18, 2020, in San Ramon, California.

I declare under penalty of perjury, under the laws of the State of California that the above is true and correct.



Signature

Armi Rafanan



Pain & Rehabilitative

CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereski, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note - SF (San Francisco) Appointment

Provider:

Supervising: Babak J. Jamasbi, M.D.

Performing: Jessica Aikin, PA-C

Encounter Date: Nov 22, 2019

Patient: Shockley, Jonathan (PT00023609)

Sex: Male

DOB: Sep 27, 1978 **Age:** 41 Year 1 Month 3 Week

Address: 1000 Sutter St Room 123, San Francisco CA 94109 **Pref. Phone(H):**
415-312-4029

Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.

Injury Date: 02/15/2019

Employer: Biotelemetry, Inc

Case Insurance: Chubb Son of Federal Ins Company

Claim No.: 040519008736

VISIT TYPE:

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley came to our office today for a follow-up visit.

SUBJECTIVE COMPLAINTS:

Patient is here to follow up on pain in his bilateral hands.

He continues to report bilateral hand pain, right greater than left. Occasionally pain radiates up his arms towards his neck. Pain is worse with repetitive use of his upper extremities, excessive

typing or computer work. Pain is better with conservative treatment.

He reports having a pain flair with the use of massage therapy, this dramatically increased his pain.

He also has been going to acupuncture treatment. This does help with his pain.

With regard to medication, he does take Advil as needed for pain.

ROS:

Constitutional:

Patient denies chills, fever, night sweats, or severe fatigue.

Head:

Patient denies dizziness or headaches.

Eyes:

Patient denies wearing corrective lenses, blurry vision, or double vision.

Neck:

Patient complains of pain but denies lumps in his neck.

Respiratory:

Patient denies difficulty breathing, cough, coughing up blood, or wheezing.

Cardiovascular:

Patient denies difficulty breathing while lying flat, fainting, abnormal heartbeat, or chest pain.

Gastrointestinal:

Patient denies constipation, heartburn, nausea, abdominal pain, black tarry stools, or throwing up blood.

Genitourinary:

Patient denies urinary incontinence, blood in urine, difficulty urinating, or painful urination.

Skin:

Patient denies itching of skin, rash, or yellowing of skin.

Neurologic:

Patient denies balance problems, poor concentration, memory loss, numbness, seizures, tremors, or weakness.

Hematologic:

Patient denies excessive bleeding or blood clots.

Psychiatric:

Patient complains of anxiety but denies depression, hallucinations and suicidal thoughts.

I have reviewed the review of systems with the patient and it is accurate as listed.

OBJECTIVE FINDINGS:

Constitutional - General Appearance:

Patient is near ideal body weight and is well groomed.

Orientation:

Patient is alert and oriented x3.

Mood and Affect:

Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Gait and Station:

No abnormalities observed.

Musculoskeletal - Strength:

RUE:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

LUE:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

Skin:

No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

Current Medications:

1. Advil (OTC)

2. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:

6 sessions of acupuncture 97813, 97814, 97026, 97124 Hand Bilateral Hands.

DIAGNOSIS:

Z79.899 Other long term (current) drug therapy

PRESCRIPTION:

1 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00.

TREATMENT PLAN:

Assessment:

during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left.

Plan:

- He will continue with acupuncture treatment, he has approximately 7 appointments remaining. Before acupuncture treatment his pain is a 4-6/10, this will decrease down to approximately 2-3/10, this allows him to use his hands more. We will request for 6 additional sessions so he can continue this.
- Ok to discontinue massage therapy, TENS dramatically increased his pain.
- If he does not respond to conservative measures, an evaluation at the Northern California functional restoration program would be indicated.
- Voltaren gel prescribed today.
- He is scheduled for QME on Jan 23, 2020.

Follow up in 4 weeks.

WORK STATUS:

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:

"I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.

*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

CC:

,Kweller, Esq., Zachary : 12/02/2019

Castro, Mario : 12/02/2019

UR, Chubb : 12/02/2019

This visit note has been electronically signed off by Jamasbi, Babak J., M.D. on 11/26/2019



Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshti, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note - SF (San Francisco) Appointment

Provider:

Supervising: Babak J. Jamasbi, M.D.

Performing: Jessica Aikin, PA-C

Encounter Date: Jan 10, 2020

Patient: Shockley, Jonathan (PT00023609)

Sex: Male

DOB: Sep 27, 1978 **Age:** 41 Year 3 Month 1 Week

Address: 1000 Sutter St Room 123, San Francisco CA 94109 **Pref. Phone(H):**
415-312-4029

Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.

Injury Date: 02/15/2019

Employer: Biotelemetry, Inc

Case Insurance: Chubb Son of Federal Ins Company

Claim No.: 040519008736

VISIT TYPE:

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley came to our office today for a follow-up visit.

SUBJECTIVE COMPLAINTS:

Patient is here to follow up on pain in his bilateral hands.

Patient denies acute changes to his pain complaints. He continues to report bilateral hand and arm pain, right greater than left. Occasionally pain radiates up from his hands into his bilateral

forearms and up towards his neck. Pain is worse with repetitive use of his upper extremities, typing, or computer work. Pain is better with conservative treatment.

He reports improvement with acupuncture treatment, he has recently been approved for 6 additional sessions. With regard to massage therapy, he reports that this did not really help as the practitioner was only able to focus on his hands, while it's really his whole arms that are painful to him. He would be interested in continuing with this treatment if it were to include both arms rather than just both hands.

With regard to medication, he reports improvement with the use of Voltaren gel. He denies side effects with the use of this medication. He requests for a refill today.

ROS:

Constitutional:

Patient denies chills, fever, night sweats, or severe fatigue.

Head:

Patient denies dizziness or headaches.

Eyes:

Patient denies wearing corrective lenses, blurry vision, or double vision.

Neck:

Patient complains of pain but denies lumps in his neck.

Respiratory:

Patient denies difficulty breathing, cough, coughing up blood, or wheezing.

Cardiovascular:

Patient denies difficulty breathing while lying flat, fainting, abnormal heartbeat, or chest pain.

Gastrointestinal:

Patient denies constipation, heartburn, nausea, abdominal pain, black tarry stools, or throwing up blood.

Genitourinary:

Patient denies urinary incontinence, blood in urine, difficulty urinating, or painful urination.

Skin:

Patient denies itching of skin, rash, or yellowing of skin.

Neurologic:

Patient denies balance problems, poor concentration, memory loss, numbness, seizures, tremors, or weakness.

Hematologic:

Patient denies excessive bleeding or blood clots.

Psychiatric:

Patient denies anxiety, depression, hallucinations, or suicidal thoughts.

I have reviewed the review of systems with the patient and it is accurate as listed.

Medical History:

PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

PSYCH/SOCIAL HISTORY

The patient does not smoke cigarettes.

The patient does not drink alcoholic beverages.

The patient does not use illicit drugs.

The patient is not married.

The patient has a significant other.

The patient has no children.

Patient does not have a family history of childhood abuse.

Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

OBJECTIVE FINDINGS:

Constitutional - General Appearance:

Patient is near ideal body weight and is well groomed.

Orientation:

Patient is alert and oriented x3.

Mood and Affect:

Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Gait and Station:

No abnormalities observed.

Musculoskeletal - Strength:

RUF:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

LUE:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

Skin:

No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

Current Medications:

1. Voltaren 1% Gel Apply to affected area daily

2. Advil (OTC)

3. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:

6 sessions of Massage Therapy (97124)- for the bilateral upper extremities.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm

M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm

M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm

M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

PRESCRIPTION:

1 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00.

TREATMENT PLAN:

Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left.

He is off work at this time.

Plan:

- He has been approved for 6 additional sessions of acupuncture treatment, we will monitor his response to this.
- We will request for 6 sessions of massage therapy for his bilateral arms, rather than just his bilateral hands.
- If he does not respond to conservative measures, an evaluation at the Northern California functional restoration program would be indicated. He continues to be off work.
- Voltaren gel refilled today.
- He is scheduled for QME on Jan 23, 2020. We will review this report when available.

Follow up in 4-6 weeks.

WORK STATUS:

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:

"I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.

*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects

of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:

Kweller, Esq., Zachary : 02/03/2020

Castro, Mario : 02/03/2020

UR, Chubb : 02/03/2020

Kweller, Esq., Zachary : 02/03/2020

Castro, Mario : 02/03/2020

This visit note has been electronically signed off by Aikin, Jessica, PA-C on 01/31/2020



Pain & Rehabilitative CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshti, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note - SF (San Francisco) Appointment

Provider:

Supervising: Babak J. Jamasbi, M.D.

Performing: Julia Fellows, PA-C

Encounter Date: Jan 15, 2020

Patient: Shockley, Jonathan (PT00023609)

Sex: Male

DOB: Sep 27, 1978 Age: 41 Year 3 Month 2 Week

Address: 1000 Sutter St Room 123, San Francisco CA 94109 **Pref. Phone(H):**
415-312-4029

Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.

Injury Date: 02/15/2019

Employer: Biotelemetry, Inc

Case Insurance: Chubb Son of Federal Ins Company

Claim No.: 040519008736

VISIT TYPE:

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley came to our office today for a follow-up visit.

SUBJECTIVE COMPLAINTS:

Patient is here to follow up on pain in his bilateral hands.

He presents for an early follow up today due to a flare up of pain. He reports increased pain,

R>L, radiating from his hand/wrist to his elbow and then up to his right shoulder. He describes this pain as burning and almost like a pulling sensation. He does report numbness and tingling as well, primarily to the 4th and 5th digits of the right upper extremity.

He reports improvement with acupuncture treatment, he has recently been approved for 6 additional sessions. With regard to massage therapy, he reports that this did not really help as the practitioner was only able to focus on his hands, while it's really his whole arms that are painful to him. He would be interested in continuing with this treatment if it were to include both arms rather than just both hands.

ROS:

Constitutional:

Patient denies chills, fever, night sweats, or severe fatigue.

Head:

Patient denies dizziness or headaches.

Eyes:

Patient denies wearing corrective lenses, blurry vision, or double vision.

Neck:

Patient complains of pain but denies lumps in his neck.

Respiratory:

Patient denies difficulty breathing, cough, coughing up blood, or wheezing.

Cardiovascular:

Patient denies difficulty breathing while lying flat, fainting, abnormal heartbeat, or chest pain.

Gastrointestinal:

Patient denies constipation, heartburn, nausea, abdominal pain, black tarry stools, or throwing up blood.

Genitourinary:

Patient denies urinary incontinence, blood in urine, difficulty urinating, or painful urination.

Skin:

Patient denies itching of skin, rash, or yellowing of skin.

Neurologic:

Patient denies balance problems, poor concentration, memory loss, numbness, seizures, tremors, or weakness.

Hematologic:

Patient denies excessive bleeding or blood clots.

Psychiatric:

Patient denies anxiety, depression, hallucinations, or suicidal thoughts.

I have reviewed the review of systems with the patient and it is accurate as listed.

Medical History:

PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.

3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

PSYCH/SOCIAL HISTORY

The patient does not smoke cigarettes.

The patient does not drink alcoholic beverages.

The patient does not use illicit drugs.

The patient is not married.

The patient has a significant other.

The patient has no children.

Patient does not have a family history of childhood abuse.

Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

OBJECTIVE FINDINGS:

Constitutional - General Appearance:

Patient is near ideal body weight and is well groomed.

Orientation:

Patient is alert and oriented x3.

Mood and Affect:

Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Gait and Station:

No abnormalities observed.

Musculoskeletal - Strength:

RUE:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

LUE:

Arm Abduction 5/5
Forearm Flexion 5/5
Forearm Extension 5/5
Wrist Extension 5/5
Thumb Apposition 5/5
Digit Abduction 5/5.

Skin:

No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

Current Medications:

1. Voltaren 1% Gel Apply to affected area daily
2. Advil (OTC)
3. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:

EMG of the Bilateral Upper Extremities to be performed at Pain & Rehabilitative Consultants Medical Group 95913; 95886.

DIAGNOSIS:

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

TREATMENT PLAN:

Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left.

He presents due to an acute increase in his upper extremity symptoms.

On exam he has full ROM of the bilateral shoulders with some discomfort. His motor exam for the elbows and hands were WNL. However, he did have a positive Tinel's at both elbow. He has never had an EMG of the upper extremities to assess for ulnar or median neuropathy before. At this time, given that his symptoms have persisted for greater than 6 months and responded only minimally to conservative treatment, we will request for an EMG at this time. Pending the results, we may consider a referral to a specialist.

He has been approved for 6 more acupuncture sessions and will scheduled these.

He is scheduled for QME on Jan 23, 2020. We will review this report when available.

Follow up in 4-6 weeks.

WORK STATUS:

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:

To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.

*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:

EMGs - Hand, Wrist, Forearm: The following has been recommended by the MTUS/ACCOEM Guidelines regarding EMGs

Electrodiagnostic Studies to Evaluate Non-specific Hand, Wrist, or Forearm Pain in Patients with Paresthesias or Other Neurological Symptoms

Recommended. Electrodiagnostic studies are recommended to evaluate non-specific hand, wrist, or forearm pain for patients with paresthesias or other neurological symptoms.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Moderate

Indications: Persistent tingling and pain, particularly symptoms characteristic of radiculopathies and entrapment neuropathies. Providers are cautioned that the prevalence rate of abnormal electrodiagnostic studies in asymptomatic populations are high (see CTS section above) and interpretations of abnormal findings should be cautious.

Frequency/Dose/Duration: Should generally be performed at least 3 weeks after symptom onset.

Rationale: There is 1 low-quality study evaluating electrodiagnostic studies for non-specific pain. However, electrodiagnostic studies may assist in diagnosing and treating the condition and thus are recommended.

Evidence: There is 1 low-quality study in Appendix 2.(1128)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Electrodiagnostic, studies, Nerve conduction, study, NCS, Electromyography, EMG, Non-specific, hand, wrist, forearm, paint controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 31 articles in PubMed, 10870 in Scopus, 298 in CINAHL, 183 from Google Scholar, and 7 in Cochrane Library. We considered for inclusion 1 from PubMed, 0 from Scopus, 1 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 11358 articles considered for inclusion, 1 randomized trials and 1 systematic studies met the inclusion criteria.

CC:

Kweller, Esq., Zachary : 01/22/2020

Castro, Mario : 01/22/2020

UR, Chubb : 01/22/2020

This visit note has been electronically signed off by Jamasbi, Babak J., M.D. on 01/21/2020

Andreas Schwerte, O.M.D., L.Ac.

300 Montgomery Street, Suite 204 San Francisco, CA 94104
Phone (415) 434-1530 Fax (415) 434-1533

SOAP Notes

PATIENT: SHOCKLEY, JONATHAN
DATE OF ONSET: 2/15/19
DOB: 9/27/1978
CLAIM#: 040519008736
DATE OF VISIT: 11/5/2019

SUBJECTIVE COMPLAINTS

COMPLAINT 1: Right & left wrist-, forearm-, and elbow-pain. Pain is constant, of sharp, aching quality, up to a 9-10 (0-10) depending on the day and activity level. There is associated numbness and paresthesia in the hand and wrist. Pain and associated symptoms are aggravated by work.

Elbow-ROM:

- Flexion: nl
- Extension: nl
- Supination: nl
- Pronation: nl

ASSESSMENT

- Wrist-, Hand-, and Elbow Pain
- Lateral Epicondylitis
- Myofascial Pain Syndrome

Prognosis: The patient is in significant discomfort limiting his ability to work and impeding on his quality of life. It seems that there is acute, severe muscle tightness/shortness causing his musculoskeletal pain and associated symptoms. The care he is receiving is reasonable and necessary.

Diagnosis:

- Lateral Epicondylitis

CURRENT PLAN

Recommended Treatments: Electro-Acupuncture, Myofascial Release, Heat/Cold Therapy.
Treatment twice weekly for two weeks followed by re-eval.

PROCEDURES:

99203; 97813; 97814; 97140, 97110

11/7/2019

SUBJECTIVE COMPLAINTS

COMPLAINT 1: Right & left wrist-, forearm-, and elbow-pain. Pain is constant, of sharp, aching quality, up to a 9 (0-10) depending on the day and activity level. There is associated numbness and paresthesia in the hand and wrist. Pain and associated symptoms are aggravated by work.

Elbow-ROM:

- Flexion: nl
- Extension: nl
- Supination: nl
- Pronation: nl

ASSESSMENT

- Wrist-, Hand-, and Elbow Pain
- Lateral Epicondylitis
- Myofascial Pain Syndrome

Prognosis: The patient is in significant discomfort limiting his ability to work and impeding on his quality of life. It seems that there is acute, severe muscle tightness/shortness causing his musculoskeletal pain and associated symptoms. The care he is receiving is reasonable and necessary.

Diagnosis:

- Lateral Epicondylitis

CURRENT PLAN

Recommended Treatments: Electro-Acupuncture, Myofascial Release, Heat/Cold Therapy. Treatment twice weekly for two weeks followed by re-eval.

PROCEDURES:

97813, 97814, 97140, 97110

11/12/19

SUBJECTIVE COMPLAINTS

COMPLAINT 1: Right & left wrist-, forearm-, and elbow-pain. Pain is constant, of sharp, aching quality, up to a 8-9 (0-10) depending on the day and activity level. There is associated numbness and paresthesia in the hand and wrist, which is now intermittent. Pain and associated symptoms are aggravated by work.

Elbow-ROM:

- Flexion: nl

- Extension: nl
- Supination: nl
- Pronation: nl

ASSESSMENT

- Wrist-, Hand-, and Elbow Pain
- Lateral Epicondylitis
- Myofascial Pain Syndrome

Prognosis: The patient is in significant discomfort limiting his ability to work and impeding on his quality of life. It seems that there is acute, severe muscle tightness/shortness causing his musculoskeletal pain and associated symptoms. The care he is receiving is reasonable and necessary.

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Treatment twice weekly for two weeks followed by re-eval.

PROCEDURES:

97813, 97814, 97140, 97110

11/7/2019

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COMPLAINT 1: Right & left wrist-, forearm-, and elbow-pain. Pain is constant, of sharp, aching quality, up to a 9 (0-10) depending on the day and activity level. There is associated numbness and paresthesia in the hand and wrist. Pain and associated symptoms are aggravated by work.

Elbow-ROM:

- Flexion: nl
- Extension: nl
- Supination: nl
- Pronation: nl

ASSESSMENT

- Wrist-, Hand-, and Elbow Pain
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97813, 97814, 97140, 97110

11/12/19

SUBJECTIVE COMPLAINTS

COMPLAINT 1: Right & left wrist-, forearm-, and elbow-pain. Pain is constant, of sharp, aching quality, up to a 8-9 (0-10) depending on the day and activity level. There is associated numbness and paresthesia in the hand and wrist, which is now intermittent. Pain and associated symptoms are aggravated by work.

Elbow-ROM:

- Flexion: nl

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
 DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

- ☒ New Request
 ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): **Shockley, Jonathan**

Date of Injury (MM/DD/YYYY): **02/15/2019**

Date of Birth (MM/DD/YYYY): **09/27/1978**

Claim Number: **040519008736**

Employer: **Biotelemetry, Inc**

Requesting Physician Information

Name: **Dr. Jamasbi, Babak J,**

Practice Name: **PRCMG**

Contact Name: **Bembem G.**

Address: **1335 Stanford Ave**

City: **Emeryville**

State: **CA**

Zip Code: **94608**

Phone: **510-647-5101 x133**

Fax Number: **510-647-5105 or 510-540-6965**

Specialty: **Pain Management**

NPI Number: **1376637199**

E-mail Address:

Claims Administrator Information

Company Name: **Chubb Son of Federal Ins Company**

Contact Name: **Castro, Mario**

Address: **P.O. Box 42065**

City: **Phoenix**

State: **AZ**

Zip Code: **85080**

Phone: **213-612-5378**

Fax Number: **800-664-1765**

E-mail Address:

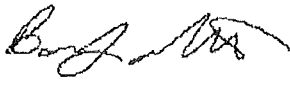
Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Other soft tissue disorders related to use, overuse and pressure, left forearm Other soft tissue disorders related to use, overuse and pressure, right forearm Other soft tissue disorders related to use, overuse and pressure, left upper arm Other soft tissue disorders related to use, overuse and pressure, right upper arm	M70.832, M70.831, M70.822, M70.821, Z79.899	EMG of the Bilateral Upper Extremities to be performed at Pain & Rehabilitative Consultants Medical Group	95913; 95886	

Treatment must be paid under the California OMFS

Peer to Peer calls: Mon-Friday:3:30pm -5pm PT. Please call (510) 647-5101 x0

		Date: 01/22/2020 at 07:58 AM(PT)	
Requesting Physician Signature:			
Claims Administrator/Utilization Review Organization (URO) Response			
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay) <input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)			
Authorization Number (if assigned):		Date:	
Authorized Agent Name:		Signature:	
Phone:	Fax Number:	E-mail Address:	
Comments:			

CC:
UR Department (if applicable):213-612-5785
Applicant Attorney (if applicable):Zachary Kweiler, Esq. 866-819-6169
Nurse Case Manager (if applicable):